California Department of Health Services
Medi-Cal Specialty Mental Health Services Consolidation
August 2002 Waiver Renewal Request
Responses to the Additional Information Request

GENERAL QUESTIONS

1. **How does the California Specialty Mental Health Services Consolidation waiver program comply with the Dear State Medicaid Director letter dated July 17, 2001 pertaining to consultation with Native Americans in relation to the waiver renewal?**

   The Department of Health Services (DHS) and the Department of Mental Health (DMH) developed a notification letter and waiver summary for the Medi-Cal Specialty Mental Health Services Consolidation (SMHSC) waiver program which was sent to Dr. Stephen Mader, M.D., Chief Medical Officer, California Area Indian Health Services, on December 10, 2002, for dissemination to tribal governments (**Attachment A**). The State requested that comments be provided to DHS within 30 days (e.g. by January 9, 2003). As of January 14, 2003, no comments have been received by DHS from federally recognized Tribes or other Tribal organizations in California.

2. **Please submit a chart similar in concept to that submitted with the 1997 renewal that addresses if/how coverage arrangements differ in each county. For each county, please specify each entity that provides specialty mental health services in that county and which services they cover. For programs, please specify how many enrollees are affected by the different programs/arrangements.**

   The chart submitted with the 1997 renewal describes the differences in coverage of specialty mental health services by the health plans contracting with the Department of Health Services. An updated chart is provided as **Attachment B-1**. All Mental Health Plans (MHPs) under the SMHSC waiver program are required to provide or arrange and pay for all covered services if the services are medically necessary to meet the beneficiary's needs. The State has also included as **Attachment B-2** a report that displays the DMH provider file for the waiver program. The report lists all providers by type of service and county of MHP, except the Fee-for-Service Medi-Cal hospitals, which are provides as **Attachment B-3**. The State does not currently prepare information that would allow the State to identify the number of enrollees affected by each provider. The State will provide reports on the number of Medi-Cal beneficiaries served by each provider in a given time period (information available from the State's claiming system) on request by CMS.

ACCESS

3. **Section II, M, page 17 – The 2002 waiver renewal request reiterates statements made in the 1999 request pertaining to access to care, including the following: "requests for services to treat urgent psychiatric conditions are acted upon within one hour of the request," and "Medi-Cal beneficiaries are able to rely on MHP provider networks for timely service referrals." We are particularly interested in these access issues in light of findings from various studies of mental health services, including the report on *Psychiatric Hospital Beds in California* (August 2001) and the 2002 Independent Assessment. The report on *Psychiatric Hospital Beds* found difficulty in accessing hospital beds, particularly for children, and the shortage experienced by 81% of participating hospitals in child and adolescent beds (p. 14). The Independent Assessment found a shortage of psychiatric services for children that "leads to appointment delays and waiting times" (page 26), a statement with which the State specifically concurred. The Independent Assessment further documented a lack of "step-down facilities" (page 27).**

   Please provide more details about findings pertaining to access to services for Medi-Cal enrollees, including information from DMH's monitoring of MHPs. Given documented provider shortages (psychiatric services, "step-down facilities"), how is the State ensuring adequate access to services for waiver enrollees?

   The full statement in the waiver renewal request reads: "The on-site implementation reviews have generally found that MHPs provide access to specialty mental health services that is equivalent or better than access prior to the waiver. Requests for services to treat urgent psychiatric conditions are acted on within one hour of the request. Medi-Cal beneficiaries with emergency psychiatric conditions receive immediate access to psychiatric inpatient hospital services. For routine service under the waiver, Medi-Cal beneficiaries are able to rely on MHP provider networks for timely service referrals, so they are not required to find a specialty mental health provider willing to accept Medi-Cal. Additionally, under the waiver, more beneficiaries are able to receive services from a wider variety of providers than in the Medi-Cal program prior to the waiver, including services from LCSWs, MFTs, and RNs with Masters' Degrees in psychiatric nursing, and community-based mental health agencies."

   The statement reiterated in the current waiver renewal that "requests for services to treat urgent psychiatric conditions are acted upon within one hour of the request," continues to be a requirement of DMH regulations at Title 9, CCR, Section 1810.405(c) and is included as a requirement of the DMH/MHP contract (Exhibit A, Attachment 1, Appendix B). In addition, MHPs are also

required through the DMH/MHP contract (Exhibit A, Attachment 1, Appendix B) to monitor the accessibility of services for routine mental health services, urgent conditions, after-hours care, and the responsiveness of the 24/7 toll-free number. The annual Medi-Cal oversight review includes in Section A and B questions to evaluate the MHPs' ability to provide for access to and authorization for routine, urgent and emergency care. Deficiencies identified in these areas would be subject to plans of correction and possible fines or other actions to ensure compliance.

The Independent Assessment provided an analysis of oversight review findings. The analysis of annual compliance review on page 115 of the Independent Assessment found that MHPs were 94.8% in compliance with access standards, which includes access to routine, urgent and emergency services for both inpatient and outpatient services; 97.5% in compliance with authorization requirements for inpatient services, which includes meeting the timeframes for authorization, and 91.2% in compliance with Quality Improvement standards, which require MHPs to set and monitor timelines for services.

In addition, DMH tracks state fair hearings and requires MHPs to submit complaint and grievance logs annually. These findings can be analyzed to determine if there are grievances or state fair hearings in relation to lack of timely access for urgent care or concerns about timely access to services. Until the most recent reporting, there have not been sufficient numbers of grievance or fair hearings to support monitoring decision-making. DMH intends to look more closely at this information in the coming year.

DMH concurs with the Independent Assessment finding that there is a shortage of psychiatric services for children that “leads to appointment delays and waiting times”. DMH has identified through the annual oversight process that while there may be delays in receiving specific services, MHPs routinely find ways to link beneficiaries to providers that meet their immediate needs. For example, the MHP may provide a beneficiary with counseling services while waiting for an opening in a day treatment program or provide the beneficiary's primary care physician with consultation on psychiatric medications while waiting for an appointment with an MHP psychiatrist.

DMH concurs with the Independent Assessment finding that there is a serious shortage of psychiatrists and a lack of both available hospital beds both in California and nationally. Declines in the number of practicing psychiatrists and the participating hospitals are occurring nationwide. In California the declines are not a result of the SMHSC waiver program, but are a result of reductions that are occurring for all populations in California and a number of economic factors including the costs of operation, lack of resources, increased nurse staffing ratios, and concerns about compliance issues. Despite the shortages, the SMHSC waiver program is providing adequate, if

not ideal, access. Penetration rate data for the three most recent available year under the waiver program show access holding steady: FY 1998-99, 5.8 percent; FY 1999-00, 6.2 percent; and FY 2000-01, 6.14 percent. Data for FY 2001-02 will be available in August 2003.

Step-down facilities in California are generally not Medi-Cal covered services, so are not the responsibility of the MHPs under the SMHSC waiver program. Step-down facilities covered by the Medi-Cal program, but not by the MHPs, include nursing facilities that have special programs for patients with mental illness. Because of the federal Institutions for Mental Diseases (IMDs) exclusion, very few beneficiaries receive these services through the Medi-Cal program. County mental health departments do provide this type of "step-down" care, to the extent resources are available, as part of their responsibilities for serving indigent populations, not as an MHP responsibility. The counties also fund step-down services under their indigent programs in Mental Health Rehabilitation Centers (MHRCs), which also fall under the IMD exclusion and are not a Medi-Cal covered service even for beneficiaries under 21 or 65 or over. The MHPs do cover crisis and adult residential treatment services, which are treatment programs provided in step-down facilities that are 16 beds or less (i.e., residential facilities that are not IMDs). The residential facilities, which include a California licensing category called Social Rehabilitation Facilities and may include MHRCs) are not covered by the MHPs or the non-waiver Medi-Cal program. Other facilities that could be considered "step-down" facilities include group homes for foster children and licensed board and care homes for adults. None of these types of facilities are the responsibility of the MHPs under the SMHSC waiver program. DMH and MHPs, because they are county mental health departments with responsibilities for the public mental health system as a whole, continue to work with other stakeholders to resolve some of these very difficult issues.

The number of Fee-for-Service/Medi-Cal (FFS/MC) hospitals decreased slightly from FY 1996-97 (prior to the first SMHSC waiver renewal period) through FY 2001-02 due to a number of hospitals closing their psychiatric units: 121 FFS/MC hospitals provided psychiatric inpatient hospital services in FY 1996-97, while 95 FFS/MC psychiatric inpatient hospitals provided services in FY 2001-02. The number of Short-Doyle/Medi-Cal (SD/MC) hospitals has also decreased from 29 in 1996-97 to 24 in FY 2001-02. The decline in participating hospitals is a result of reductions that are occurring for all populations in California and nationally, not a result of the SMHSC waiver program alone. To some extent, the decline represents a positive trend toward early intervention and community-based, rather than institutional, treatment of individuals in crisis. On the other hand, ensuring the availability of psychiatric inpatient hospital services, when necessary, is essential to continued successful operation of the waiver program.

DMH is continuing to study these problems and work towards potential solutions. The State Quality Improvement Council (SQIC) is currently studying several issues related to psychiatric inpatient hospital services, including a re-hospitalization rate special study conducted by the SQIC Inpatient Treatment Review Workgroup. The Community Mental Health Services Workgroup of the SQIC is currently studying the timeliness of medication support services in relation to a beneficiary's initial services from the MHP. Several MHPs have agreed to participate in the study. Preliminary data are currently being reviewed. The workgroup has also conducted a recent survey of MHP quality improvement coordinators to obtain information about quality improvement projects and results and MHP policies on timeliness of services. Once studies are completed, the SQIC is expected to make recommendations to DMH for action. MHPs are currently conducting Latino access studies as part of their FY 2002-03 quality improvement workplans as a result of an SQIC recommendation to DMH.

4. Children with Special Health Care Needs criteria

a) Has the Children with Special Health Care Needs (CSHCN) Task Force identified any issues specific to the services CSHCN receive under the waiver?

DHS' CSHCN Task Force, convened by DHS' Medi-Cal Managed Care Division (MMCD), has not identified any issues specific to the services CSHCN receive under the waiver. The primary focus of the Task Force has been on the responsibilities of the physical care health plans contracting with DHS to provide comprehensive Medi-Cal coverage. DMH's Children's Medical Director attends the Task Force meetings and presented on the SMHSC waiver program at the July 2002 meeting. The Task Force issue that overlaps the two programs is the issue of coordination of care between the MHPs and the health plans. The CSHCN Task Force has not identified any issues specific to the services CSHCN receive under the SMHSC waiver program as action items for the group.

b) The data and information that the State submitted to meet the terms and conditions of the waiver pertaining to CSHCN is a rich source of information about specialty mental health services provided to children. Given the feedback that CMS provided regarding the data submitted, has the State considered using the data to develop specific tracking/monitoring reports? How will the data be analyzed/used in the future?

DMH has made extensive use of the data in FY 2001-02 and FY 2002-03, analyzing and identifying trends related to growth and costs under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

DMH has used the outcome of that analysis to identify areas of the EPSDT program where there has been ambiguity and a lack of guidelines. As a result of this extensive analysis and findings, DMH worked with California Mental Health Directors Association (CMHDA) and other stakeholders to produce and issue DMH Information Notice No. 02-06 (**Attachment C**), establishing changes in Medi-Cal requirements for day treatment and DMH Information Notice No. 02-08 (**Attachment D**) establishing changes in management of therapeutic behavioral services (TBS).

DMH uses claims data to establish the sampling methodology for the chart samples for the Medi-Cal Oversight annual outpatient chart reviews. DMH staff are now tracking EPSDT trends through quarterly claim reports that can be compared to previous years to analyze utilization. An analysis of claims data identified several MHPs with TBS cases that appear to have excessive costs. DMH has developed a sampling methodology for TBS chart reviews that will result in the review of all cases with claims for TBS at or above $25,000 in FY 2001-02. The data are also being used to develop a Statewide Maximum Allowance for TBS, which DMH anticipates proposing to DHS for implementation in FY 2003-04 as a State Plan Amendment.

DMH expects to continue to develop better methods for using Medi-Cal data to improve its monitoring efforts for the waiver program.

5. **Section IV, A, 6, page 38 -- The waiver states that CMHDA, serving as an ASO, authorizes and pays for basic outpatient specialty mental health services needed by foster children who are placed out-of-county. How are inpatient services handled for out-of-county foster children?**

MHPs are responsible for and required to provide psychiatric inpatient hospital services to their beneficiaries whether or not the beneficiary is currently in the MHP's geographic area. Virtually all psychiatric inpatient hospital services are provided to beneficiaries with emergency psychiatric conditions. Beneficiaries may be admitted to any hospital that provides these services, whether or not the hospital has a contract with the MHP of the beneficiary. Hospitals, under federal and state law, are required to admit and stabilize patients in an emergency. There is no access problem specific to foster children placed out-of-county. The Californians living in the more rural areas of California, however, do not have close geographic access to hospitals that offer psychiatric inpatient hospital services. In these areas, individuals needing psychiatric inpatient hospital services are transported to the closest available hospital or local providers find other ways to meet the patients' needs. This is true for Medi-Cal beneficiaries as well as the general population.

INFORMING

6. **Section II, A, 5, page 22 -- The waiver renewal states that the State "provides ongoing information on the program to new applicants through county welfare departments." Please define "ongoing," and describe the information that is provided on an ongoing basis. The renewal also states that the "State will issue annual notices regarding the information available from the MHPs to all Medi-Cal households, so all beneficiaries will receive information about the program on a regular basis." What information is the State currently providing on an annual basis?**

   The State provides on-going information on the SMHSC waiver program to new Medi-Cal applicants in the form of the initial notice (**Attachment E**) through county welfare departments at the time they make the initial determination of Medi-Cal eligibility. The State has provided translations of the notice in threshold languages through county welfare departments as they became available.

   As described in the waiver renewal application, the State has developed a revised notice, which was included as APPENDIX III-A-5-b in the waiver renewal request. The revised notice was developed with input from program stakeholders, primarily the DMH Client and Family Member Task Force (CFMTF) and the CMHDA Medi-Cal Policy Committee. Although DMH intended the notice to be an annual distribution, the revision was not finalized until March 2002. It is now clear that the notice will need to be revised to meet the new annual notice requirement at Title 42, Code of Federal Regulations (CFR), Section 438.10(f)(2), in order to incorporate the information requirements contained in Sections 438.10(f)(6) and 438.10(g). Although the revised notice would have been an improvement on the initial notices, DMH believes the initial notices are adequate until the annual noticing process is established by August 2003 to meet the new federal regulatory requirements. The State anticipates developing the notice language between February and June 2003 and will be keeping the Centers for Medicare and Medicaid Services (CMS) informed through the regular monthly conference calls and other means as may be required.

7. **Section II, A, 6, page 24 -- The State notes that beneficiary brochures and other program information are translated by each MHP into each threshold language for that county. How do MHPs address the needs of non-English speaking beneficiaries whose language group do not meet the criteria of a "threshold language?"**

   Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual's

participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, DMH requires that all MHPs must ensure that all Medi-Cal LEP members have equal access to all covered services.

DMH operationalized this requirement in Title 9, CCR, 1810.410, which describes the requirement for MHPs to submit a Cultural Competence Plan (CCP) that addresses the cultural and linguistic needs of all Medi-Cal beneficiaries, in contractual requirements that MHPs comply with their CCPs, and in the policy and standards guidelines in DMH Information Notice No. 02-03 (**Attachment F**).

These requirements include the requirement that LEP individuals should be informed in a language they understand that they have a right to free language assistance services; that MHPs have policies and procedures that show evidence of the capability to refer and otherwise link Medi-Cal beneficiaries who do not meet the threshold language criteria, with culturally and linguistically appropriate services; that MHPs have a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, that can provide information to all Medi-Cal beneficiaries about access to care, including care for urgent and emergency conditions and information about beneficiary protection. MHPs are specifically required to have policies and procedures for meeting language needs for consumers who do not meet threshold language criteria.

DMH has integrated cultural competence requirements into the annual review protocol. For example, as part of the review of access, reviewers look for evidence of the availability of the 24-hour phone line in all languages; a system for making provider lists, including options for cultural and linguistic services, available on request; that LEP beneficiaries are informed, in their own language, that they have a right to free language assistance; policies and procedures for linking beneficiaries who do not speak threshold languages to appropriate services. The chart review component of the reviews look for evidence that interpreter services are offered to beneficiaries with LEP, that responses to offers of interpreter services, that personal correspondence is in the beneficiary's primary language, and that information is provided to beneficiaries with visual or hearing impairments in an appropriate form.

MONITORING

8. **Section II, M, page 17 -- The waiver renewal states that the State reviews of MHPs consisted of "chart reviews of SD/MC inpatient hospitals and outpatient programs." Who reviews FFS/MC inpatient hospitals? Does this statement refer to all outpatient programs, or only those outpatient programs traditionally claimed through SD/MC? If the latter, who**

reviews those outpatient programs traditionally claimed through FFS/MC?

"SD/MC providers" is a term frequently used to refer to outpatient providers that participated in the SD/MC program as it existed prior to the waiver program. In the state regulations governing the program these providers are termed "organizational providers." "FFS/MC providers" is a term frequently used to refer to outpatient providers that participated in the regular FFS/MC program prior to consolidation under the waiver program. In state regulations governing the program these providers are termed individual and group providers. SD/MC hospital is the term used to refer to hospitals that bill through the SD/MC claiming system under the waiver program; FFS/MC hospital is the term used to refer to hospitals that bill the regular Medi-Cal fiscal intermediary (Electronic Data Systems) under the waiver program.

DMH reviews charts for services delivered through county owed or operated hospitals (typically SD/MC hospitals) and through organizational providers. DMH does not currently perform chart reviews for services delivered by hospitals that are not owned or operated by counties (typically FFS/MC hospitals) or individual and group providers. Given the limited resources available for this function, DMH elected to perform chart reviews where there were likely to be the most limited review of services by the MHP and where there could be the greatest financial incentive to deliver unnecessary services. The SMHSC waiver program is not capitated. Although the program has been cost-effective, the federal exposure for federal financial participation (FFP) is not capped by the current payment arrangements between the State and the MHPs. For EPSDT services, neither state nor federal funds are capped. The purpose of the chart reviews has been both the ensure proper claiming of FFP and to review quality of care with respect to documentation practices. The State is willing to shift this focus, if required to do so by CMS as a condition of waiver approval. This will not increase the sample size selected for review, but will change the nature of the selected charts.

9. **Independent Assessment, pages 25, 37, 38, 47 -- The Independent Assessment documents a number of disparities in requirements on, and oversight of, FFS/MC providers. Does State monitoring efforts look separately at SD/MC and FFS/MC providers? If so, what findings have been identified? If not, how does the State plan to address these monitoring disparities? For example, while the State holds that they prefer to rely on goals for timeliness of service rather than "require higher levels of capacity monitoring by network fee-for-service providers," has the State found any disparities in timeliness between SD/MC and FFS/MC providers?**

The State monitoring efforts as a whole do not look separately at organizational providers and individual and group providers (please see definitions in the response to question 8 above). The review protocol was provide as Exhibit 6 in the waiver renewal request. The review process ensures that MHPs have systems in place to meet waiver program requirement in the areas of access, authorization of services, beneficiary protections, funding and reporting requirements, interface with physical health care, provider relations, and quality improvement programs. In these areas, MHP systems that affect both types of providers and the MHP as a provider are reviewed, although the focus is on MHP administrative systems. Only the chart review component of the annual reviews looks directly at providers. For that component, the review sample focuses exclusively on county owned and operated hospitals and on organizational providers. Please see the response to question 8 above for information on the State's rationale for this choice.

The State expects most direct monitoring of providers to be done by the MHPs. The State has established very general requirements on the MHPs to ensure that services are delivered appropriately. This has given MHPs the flexibility to decide whether to concentrate their efforts through authorization systems that look at the medical necessity of services prior to service delivery or to do post-service utilization reviews. In general MHPs have used authorization systems for individual and group providers (and are required to do so for FFS/MC hospital providers) and post-service reviews for organizational providers, including the MHP as provider. Providers have access to the provider problem resolution processes each MHP is required to provide under Title 9, CCR, Section 1850.305 to resolve payment disputes and other issues.

No specific situations were identified in the Independent Assessment, nor have specific disparities in timelines for services been reported to DMH. The State's annual compliance reviews would not identify the issue, nor would claims data indicate this information. DMH has the authority, however, to investigate complaints about providers from beneficiaries, provider staff and the MHPs and does do so. DMH has recently participated in focused reviews of individual and group providers at the request of the MHPs. Since 1998, DMH has done at least two investigations of MHPs in response to complaints from or related to individual and group providers. Complaints are more likely to be raised with respect to actions of the MHP as a provider or other organizational providers. Most of these situations have been discussed with CMS on its monthly conference calls with the State on the waiver program. DMH is prepared as necessary and appropriate to conduct focused reviews when complaints or concerns are brought to DMH's attention. The State will provide additional information on the specific situations if needed.

FINANCIAL QUESTIONS

10. Section II, I, page 16 – Enrollment projections: Given that the number of enrollees for the last 3 years (FY99/00 to 01/02) has increased on an average of 6% per year, why does the State project enrollment increases of only 3% per year?

The actual number of average monthly Medi-Cal beneficiaries was compiled from the California Department of Health Services' (DHS) Medi-Cal Eligibility File for FY 1991-92 through FY 2000-01. These figures represent actual Medi-Cal beneficiary enrollment (including retroactive enrollment) throughout the State, excluding San Mateo and Solano Counties. FY 2000-01 was the most recent year of actual enrollment, because of retroactive Medi-Cal enrollment and the timing of when the waiver renewal was prepared. Medi-Cal beneficiaries for FY 2001-02 and FY 2002-03 were estimated by applying the percent change in Medi-Cal beneficiaries, by Medi-Cal aid code group, as developed by DHS Fiscal Forecasting and Data Management Branch, to the actual number of Medi-Cal beneficiaries in FY 2000-01.

DHS Fiscal Forecasting and Data Management Branch has developed a complex forecasting model to estimate the change in Medi-Cal beneficiaries that includes such factors as projected economic growth, legislative changes, population changes, demographic changes, etc. The Medi-Cal estimates prepared by DHS Fiscal Forecasting and Data Management Branch are used to develop the State's Medi-Cal budget. DHS Fiscal Forecasting and Data Management Branch estimates a slower rate of growth in overall Medi-Cal beneficiaries in FY 2002-03 due to several factors, including a decrease in the number of Medi-Cal families on public assistance.

The percent changes in Medi-Cal beneficiaries estimated by DHS Fiscal Forecasting and Data Management Branch for FY 2002-03 are assumed to represent the estimated percent changes in FY 2003-04 and FY 2004-05. This assumption was chosen instead of developing historical trends because the most recent estimated percent changes in Medi-Cal beneficiaries incorporate the most recent economic, demographic, and program information. A trend based on historical enrollment would not necessarily incorporate these factors. Thus, the slower growth estimated by DHS Fiscal Forecasting and Data Management Branch for FY 2002-03 was assumed to continue through FY 2004-05.

11. Realignment funds:

a) Section II, N, pages18-21 – Has the State taken into account any reductions in realignment revenues due to reductions in sales taxes due to the economy?

The realignment amounts shown in the waiver include actual sales tax and vehicle license fee (VLF) growth through FY 1999-00. These amounts were assumed to remain constant in future years, so that the realignment amounts shown in the waiver do not reflect any future year growth in sales tax or VLF revenues. In FY 2000-01, there was additional sales tax and VLF growth of approximately $90 million that was not included in the waiver. Also, the May Revision of the Governor's Budget for FY 2002-03 estimated a slight increase in sales tax revenues in FY 2001-02 and a larger increase in FY 2002-03. These estimates show a slower growth rate in sales tax revenues, but still reflect an overall increase compared to prior years. These increases, coupled with continued growth in VLFs, indicate that the amounts shown in the waiver probably understate the amount of actual realignment funds that will be available. This understatement of realignment funding was intentional, because it shows that, even under very conservative assumptions, sufficient realignment revenues are available as State match for Medi-Cal FFP.

b) Section II, N, page 20 – In a number of instances, the waiver refers to realignment dollars – including Table S1 in Appendix II-N, Table S2 (p. 20), and in the second paragraph on p. 21. Are these realignment dollars the subset of all realignment funds deposited into counties' mental health accounts, or all realignment dollars that counties receive?

The realignment funds shown in the waiver are the total amount of realignment funds deposited into counties' mental health accounts. This is a subset of the overall realignment amount counties receive, which, in addition to mental health funds, includes funding for social services and health programs.

12. Section II, N, page 19 -- We would like more detail regarding the formula for calculating increases in SGFs transferred to counties with above average need. Please address the following:

a) Please further describe how county MHPs' weighted relative need is estimated. How did the State develop the statewide weighted-average cost per Medi-Cal beneficiary in FY 1993-94?

The weighted relative need of a county MHP provides an indication of the funding level required to bring the MHP to the statewide weighted average Medi-Cal payment per beneficiary, weighted by aid code group. Medi-Cal payments included actual FY 1993-94 FFS/MC and actual FY 1993-94 SD/MC inpatient, outpatient, and long term care payments.

Medi-Cal payments were weighted based on the relationship between the FY 1993-94 Medi-Cal payments per beneficiary in four aid code groupings

(Families, Foster Care, Disabled, and All Other) and the overall statewide average Medi-Cal payments per beneficiary. **Table 1**, below, shows the statewide Medi-Cal payments per beneficiary, by aid code group, and the corresponding weight assigned to each aid code group.

Table 1

Statewide Medi-Cal Payments per Beneficiary
FY 1993-94
(FFP and State Match)

Medi-Cal Aid Code Groupings	FY 1993-94 Payments per Beneficiary	Beneficiary Weighting Factor
Families	$41.15	0.3438
Foster Care	746.69	6.2391
Disabled	566.64	4.7346
All Other	39.22	0.3277
Total	$119.68	11.6452

The relationship between statewide Medi-Cal payments per beneficiary for a specific aid code grouping and the total statewide average Medi-Cal payments per beneficiary was multiplied by the number of beneficiaries in the aid code group in order to "weight" the beneficiaries. For example, the number of Disabled Medi-Cal beneficiaries in each county was multiplied by 4.7346 (the Beneficiary Weighting Factor from Table 1). The weighted beneficiaries of each aid code group then were summed for each county to determine the weighted beneficiaries in each county. Total FY 1993-94 Medi-Cal payments were divided by the weighted beneficiaries to determine the weighted Medi-Cal payments per beneficiary in each county.

The difference between the statewide weighted average Medi-Cal payment per beneficiary and each MHP's weighted Medi-Cal payment per beneficiary was multiplied by the number of FY 1993-94 weighted beneficiaries in the county for all MHPs with lower than average weighted Medi-Cal payments per beneficiary. This represents the level of Medi-Cal funding required for an individual MHP to reach the statewide weighted average Medi-Cal payment per beneficiary. Each MHP's Medi-Cal funding requirements were divided by the total statewide funding requirements to determine the weighted relative need of each MHP.

b) Why hasn't weighted relative need been recalculated since the waiver program began? How can the State assure that those MHPs

that have not received a growth increase since FY 1995-96 are still above the weighted average cost per Medi-Cal beneficiary?

Weighted relative need has not been recalculated because DMH and CMHDA have not been able to develop and agree to a methodology that would account for the annual State General Fund allocations to the MHPs in the recalculation of weighted relative need. It would seem to be a relatively straightforward calculation. The most recent Medi-Cal expenditures would be divided by the most recent weighted Medi-Cal beneficiaries to determine a revised relative need. The change, however, would provide increased State General Funds to some MHPs, while reducing funds to others, which could make implementation of a change difficult. If CMS requests, DMH will again discuss with CMHDA the desire to recalculate weighted relative need and try to gain consensus on a methodology.

The State cannot assure that those MHPs that have not received a growth increase are still above the average cost per Medi-Cal beneficiary; however, this has not been a critical factor for DMH or CMHDA in the annual process of developing the allocation methodology. The agreement between DMH and CMHDA, developed in accordance with California Welfare and Institutions Code, Section 5778(k) regarding the annual allocation of these funds, has not specified this as a requirement of the allocation formula. If it becomes an issue, DMH and CMHDA would review the allocation methodology and modify if necessary.

c) **If the relative need increase has been frozen or has not occurred since the beginning of the program, please clarify that any further cost increases due to changes in enrollment, utilization, or cost of living come from a county's realignment (or other) funds.**

The state match for increases in Medi-Cal costs due to enrollment, utilization, or cost of living may come from an MHP's realignment funds or other funds. The baseline amount of State General Funds allocated to MHPs for managed care is more than sufficient to cover the state matching share of costs of Medi-Cal inpatient hospital services, although some MHPs produce more "savings" than other. MHPs that have not fully committed their annual State General Fund Managed Care allocation have the ability to absorb increased Medi-Cal costs through the annual allocation. Utilization and inflation increases in children's services have been paid through EPSDT State General Funds in addition to FFP. Most other Medi-Cal cost increases are most likely covered through realignment funds and increases in FFP for services delivered.

13. Section II, N, page 20, Table S2 -- It is our understanding that the State's intent in showing a "surplus" in Table S2 is to illustrate that counties have ample funds to use for Title XIX match. However, it is also our understanding that county realignment funds are also intended to be used to provide services to non-Medicaid populations and that, therefore, there are other uses for these funds. Given these competing demands, how does the State ensure that adequate funds will be available for Title XIX match? Overall, is there a monitoring process that assures that mental health realignment allocations are used for mental health services? Is the "surplus" referred to in Table S2 used solely for non-Medi-Cal mental health services?

The intent of Table S2 is to show there are sufficient realignment funds to use as State match for Medi-Cal FFP. The surplus in Table S2 may be used to provide services to non-Medi-Cal populations as well as provide non-Medi-Cal services to Medi-Cal clients (e.g., costs of room and board in an Institution for Mental Diseases). The surplus shown in the waiver renewal request is used for activities not reimbursed through the Medi-Cal program, which could include services to non-Medi-Cal clients, non-Medi-Cal services to Medi-Cal clients, and MHP administrative activities.

The State does not directly monitor the use of realignment funds. The State's system has built-in financial incentives that help ensure that the Medi-Cal obligation is met. Counties obtain FFP for Medi-Cal services, saving half the cost to realignment funds. State statute is clear that the counties' obligations to the non-Medi-Cal population is subject to the availability of resources. For example, Welfare and Institutions Code, Section 5600.2 provides in part: "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable . . . "

Each county is required by statute to have a Mental Health Board that advises the Board of Supervisors and county mental health departments. The boards have significant client and family member representation and must be consulted on county actions to make legal transfers among mental health, health and social services realignment funds. The boards have the ability to raise issues politically if counties divert funds inappropriately, as do other stakeholders.

DMH requires MHPs to certify that the State match is available as part of the standard process for claiming FFP through the SD/MC claiming system. DMH withholds sufficient funds from the annual Managed Care allocations to cover the state match for claims for psychiatric inpatient hospital services in FFS/MC hospitals paid by EDS, then settles with the MHPs after the payments are made. The DMH annual compliance reviews ensure that the

MHPs have systems in place that will assure that the MHPs meet their Medi-Cal obligations under the SMHSC waiver program. MHP beneficiary problem resolution processes give beneficiaries themselves an opportunity to address individual problems, as does the DMH Ombudsman service and the State fair hearing process.

14. MAA Expenses

a) Table 2: Medi-Cal Specialty Mental Health Services Annual Costs Under the Waiver — According to CMS' FY2001 financial management review of the MAA program, the portion of the total computable MAA expenditures claimed through DMH was approximately $11 million. According to Table 2, actual MAA expenses were approximately $26 million in SFY2000-01. Please explain the differences.

Actual Medi-Cal Administrative Activities (MAA) costs from FY 1996-97 through FY 1999-00 were compiled from the SD/MC cost report, which may be different and is more accurate than the amount claimed. FY 2000-01 was estimated using a linear trend in historical MAA costs from FY 1996-97 through FY 1999-00, which included a large increase in FY 1999-00 as part of the trend. Thus, FY 2000-01 in the waiver renewal request represents an estimated amount. Also, the $11 million identified through the CMS review may have only included FFP and not the State match, while the figures shown in the waiver renewal request include both FFP and State match.

b) Section V, B, 1, page 58 – Please explain why the State attributed the significant increase (58% increased PMPM) in the MAA expenses during SFY 99/00 to the waiver. Why does the State expect that MAA expenses will increase more under the waiver than without the waiver?

As discussed in the waiver, the counties' MAA plans and billing do not identify whether or not components of an allowable activity might include activities that would not be done absent the waiver program. The State, therefore, could not identify a specific dollar amount as a waiver program cost. It seemed more reasonable to attribute the significant increase during the waiver period to the waiver program, rather than to risk underreporting costs under the waiver program.

Counties are able to report and claim reimbursement for MAA costs that are attributable to the waiver program for activities the county would not be performing if the county was not serving as the county MHP under the waiver program. For example, counties might not undertake the same level of Medi-Cal outreach without the waiver program. MHP access-lines represent costs that would not usually be considered direct mental health

services. Most MHPs schedule and conduct face-to-face assessments in response to access-line calls, rather than conduct immediate assessments over the telephone. The cost of the access line could be considered a component of Medi-Cal outreach activities.

15. Tables 1 and 2: Medi-Cal Specialty Mental Health Services Annual Costs Under the Waiver -- Please provide more detail regarding your assumptions about growth in inpatient hospital spending without the waiver. In your documentation, you note that the number of hospitals providing inpatient psychiatric care fell both for Medi-Cal beneficiaries and for all patient populations in California and nationally. How do you reconcile this fact with your assumption that costs for inpatient care would have continued to grow rapidly without the waiver? How did MHPs control spending on inpatient hospital services so effectively under the waiver?

Actual data for FFS/MC inpatient hospital services from FY 1991-92 through FY 1993-94 were used to develop estimated payments for FY 1994-95 through FY 2004-05 for each Medi-Cal aid code group. It was assumed that an inverse exponential relationship existed in the FFS/MC inpatient costs per member per month (PMPM) rather than a linear relationship, primarily due to resource constraints on the service delivery system. Thus, estimated FFS/MC inpatient costs PMPM were assumed to change at a decreasing rate. The method of least squares was applied to the actual costs PMPM for each Medi-Cal aid code group to develop the best estimates of future year costs PMPM.

The number of hospitals providing psychiatric inpatient hospital services fell from 121 hospitals in FY 1996-97 to 95 in FY 2000-01. However, as discussed in Appendix A-14 of the initial *Medi-Cal Psychiatric Inpatient Hospital Services Consolidation Waiver* (April 1994), the statewide vacancy rate in these hospitals was approximately 50 percent in 1992. Thus, there were excess psychiatric inpatient beds prior to the start of the waiver program. Prior to the waiver program, the State prioritized the cost-control measures it applied to hospital costs. The major effort was applied to the medical hospitalizations through the Selective Provider Contracting waiver program that involved hospital rates that were negotiated for the State by the California Medical Assistance Commission. For the most part, the State paid cost for psychiatric inpatient hospital services. The cost-effectiveness calculations in the waiver renewal request assume that the State would continue to pay cost for these services.

MHPs have been able to negotiate hospital contracts at rates that are significantly lower than the cost-based rates paid prior to the waiver. The MHPs, through selective contracting with the most efficient hospitals with expertise in mental illness, have been able to decrease the costs of Medi-Cal

inpatient services under the waiver. Hospitals that do not contract with the MHPs are paid the weighted average rate for contract hospitals in the same region. There have been some changes in the number of admissions and length of stays, but recent data are inconclusive about trends. The State believes that the ability of MHPs to negotiate lower hospital rates under the waiver program is the reason MHPs have been able to control spending on inpatient hospital services so effectively under the waiver program.

16. Sole source (Exhibit 2)

a. In order to help place Medi-Cal into the broader market for mental health services in California, please explain the degree to which Medi-Cal providers overlap with providers that serve the broader population, and the extent to which the services that private companies offer differ from Medi-Cal services. Also, please provide information regarding private companies that either offer mental health insurance products in California or provide administrative services for large businesses that self-insure for health care costs.

The State does not track the extent to which Medi-Cal providers participating in the waiver program also serve the broader population. DMH does have information available in its Client and Services Information (CSI) system that identifies the total number of Medi-Cal and non-Medi-Cal clients served by the public mental health system; however, DMH is not yet able to separate these two types of clients for reporting purposes. Most of the non-Medi-Cal clients would be individuals in the counties' indigent programs. Individual and group providers typically have private practices, but DMH does not have information on the extent of these private practices.

The State's Department of Managed Health Care (DMHC) recently released proposed regulations to clarify issues related to California's mental health parity legislation (see **Attachment G**). The proposal describes the kinds of services DMHC currently sees as covered by commercial health plans (i.e., traditional therapy services delivered by licensed professionals). DMH provided comments to the regulations suggesting that the scope of benefits include some rehabilitative services, but no action has been taken as yet on the DMH suggestions (see **Attachment H**). Non-managed care health insurers provide a similarly limited scope of benefits. Services such as target case management, training in activities of daily living, and therapeutic behavioral services are not provided by commercial plans or insurers.

DMHC lists all licensed health plans (currently 122) on its website at http://www.dmhc.ca.gov/mcp/showall.asp. Only six of these appear to be plans that specialize in mental health care, including three that have

subcontracting relationships with MHPs (PacificCare, United Behavioral Health and ValueOptions). The State does not have information on other private companies that may be willing to provide administrative services for large businesses that self-insure for health care costs. The administrative services organizations that do contract with MHPs for these types of functions were selected through formal procurement processes.

b. Has the State has brought up this issue with the program's stakeholders since the last renewal? Is sole source explicitly supported by stakeholders?

The sole source continues to be supported by stakeholders. During the planning phase of consolidation, DMH utilized the Managed Care Steering Committee, which was comprised of about 40 stakeholder organizations representing state agencies, providers, clients, and family members, to develop the sole source exemption. DMH currently includes several other committees to make ongoing recommendations regarding quality issues and policy development. These include the SQIC, the Client and Family Member Task Force (CFMTF), the Cultural Competence Advisory Committee, and the Compliance Advisory Committee (CAC). The State did not formally raise the issue of the sole source exemption issue with the program's stakeholders as part of the development of this waiver renewal request. Most of the discussion with some of the current stakeholder groups (CMHDA, CFMTF, CAC) on the waiver renewal has focused on the need to plan for system changes related to the new Medicaid managed care regulations. Part of the discussions have included the State's proposals for waivers of the new regulations needed to allow continuation of the current contracting relationships with county mental health department. The discussions have always accepted that the waivers are essential.

The SMHSC waiver program received significant, explicit support from counties, legislators, and advocates for the last waiver renewal. This support has not been withdrawn. The Independent Assessment included meetings with beneficiary and provider advocate groups. As noted on page v of the Executive Summary "Overall, advocates believe that California would best be served by the SMHSC waiver program's continuation."

INDEPENDENT ASSESSMENT

17. Independent Assessment, page 31 -- Please clarify if MHPs that provide services above the Medi-Cal benefit package are not claiming FFP for the provision of these services.

MHPs may provide additional services to Medi-Cal beneficiaries to meet their mental health needs that are not reimbursed through Medi-Cal. These services may be reimbursed through alternative funding sources or paid for by the county without supplemental reimbursement. For example, many counties offer vocational services in the form of supported employment for mental health clients including Medi-Cal beneficiaries, which are not subject to Medi-Cal reimbursement. Counties providing such services frequently contract with the Department of Rehabilitation and enter into cooperative programs which include the MHPs to provide the vocational benefits. Similarly, many counties provide for transportation and payee services which are funded only by the county through their county dollars. MHPs are prevented from claiming FFP for these non-Medi-Cal services by edits in the SD/MC claiming system that accept only codes for Medi-Cal covered services and are monitored for compliance through the annual chart reviews that disallow FFP if the service claimed is not charted as a Medi-Cal covered service. The State also has systems in place to follow up on allegations of fraud.

18. Independent Assessment, page 10 – The Independent Assessment notes that the move to capitation is "under development." Is the State still considering moving the waiver to capitation in the future? What is the current timetable for such a change?

The State continues to explore ways to move the waiver program to a capitated or other similar risk model. State law requires DMH to work with CMHDA to develop an acceptable methodology. DMH has done so throughout the previous waiver periods generally by convening one or two meetings a year with key fiscal and management representatives from CMHDA. DMH and CMHDA met recently to discuss the future direction of the SMHSC waiver program in relation to the dramatic budget deficit facing California, in addition to the pending implementation of both the new Medicaid managed care regulations and the new transaction and privacy requirements related to the Health Insurance Portability and Accountability Act. At the time the waiver program was originally authorized under State law, a Medicaid block grant appeared imminent. If federal block grant funding had materialized, the program would have moved immediately to a capitated model. Absent this impetus, however, the State is faced with resolving the ongoing disparities in historical costs of Medi-Cal specialty mental health services among counties and MHP concerns about assuming additional risk.

The disparity in historical costs is being addressed by allocating State General Fund increases in the annual Managed Care allocation to MHPs that were below the historical average cost per beneficiary of Medi-Cal specialty mental health services (see the discussion on question 12 above). Although this strategy has made significant changes in the funding difference among MHPs, the State is still some years away from bringing all MHPs to at least

the historical average funding level. Prior to the initial implementation of the waiver program in January 1995, MHPs in 37 of 55 counties (San Mateo, Santa Barbara and Solano Counties were not included in the original waiver program) were below the statewide average Medi-Cal payment per beneficiary for specialty mental health services. Under the waiver program, as of FY 1999-00, only 24 counties are below the historical statewide average Medi-Cal payment per beneficiary. This represents a decrease of 35 percent in the number of below average counties. The MHP with the lowest Medi-Cal payment per beneficiary has gone from 17 percent of the statewide average to 70 percent of the statewide average. Although this represents substantial progress, the problem remains significant.

Regardless of the disparity issue, the State is unlikely to be able to move to a capitated program in the current economic climate. MHPs are able to obtain FFP for the full cost of services up to a State Maximum Allowance. Any capitated system would put this feature at risk. MHPs are not expected to be receptive to a change in this component of the program.

The State is continuing to field test the use of case rates, essentially user-based capitation rates, to provide FFP in the Medi-Cal Mental Health Care Field Test (San Mateo County) waiver program. DMH is continuing to analyze the information from the Independent Assessment of the San Mateo program to determine the positive and negative aspects of operating a case rate model. The monitoring efforts that would be required to maintain a statewide case rate system effectively, however, are currently beyond the State's resources.